PharmaCare Direct Mail Service Form

To receive your prescription medication in the mail:

- Complete the requested information below
- Be sure to provide the primary participant's (member) ID number
- Provide your doctor's name and phone number for each prescription included with the order form
- Place your prescription or refill request with your copayment in an envelope and send it to PharmaCare Direct, P. O. Box 18910, Fairfield, OH 45018-9945.
- To enroll, you may fax this form to (866) 399-3654. **PLEASE NOTE:** In order for us to accept a faxed prescription, the prescription must be faxed with a cover sheet directly from the physician's office. ***Prescriptions faxed by patients are not valid and will not be accepted.***
- NOTE: you can now refill your prescriptions using our web site, www.pharmacare.com

PRIMARY INFORMATION

Participant's Name

Participant's Member ID Number

Street Address

City State Zip

Daytime Phone

Evening Phone

Company Name

A pharmacist is available during normal business hours to answer questions concerning your prescription.

PAYMENT INFORMATION

☐ I have enclosed my check or money order, made payable to PharmaCare Direct.
☐ Please bill my credit card.
☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Cardholder signature

Card No. Exp.Date

Number of Prescriptions

Total amount enclosed Date

Participant's Signature

I certify that the information on this form is correct. I understand that generic drugs will be dispensed in all cases where legally permissible and medically appropriate.

PATIENT'S NAME	BIRTH DATE	GENDER	PATIENT IS:			DOCTOR'S NAME & PHONE #
			SELF	SPOUSE	OTHER	

FOR HELP WITH PLACING YOUR ORDER CALL 1-800-346-9113

MORE >>>

PATIENT PROFILE

PLEASE CHECK APPROPRIATE BOX

			ALLERGIES					***HEALTH CONDITIONS***					
PRINT OR TYPE *Include last names if not the same as participant's*	DATE OF BIRTH	GENDER	ASPIRIN	NONE	PENICILLIN	CODEINE	SULFA	THYROID	DIABETES	GLAUCOMA	HEART CONDITION	HIGH BLOOD PRESSURE	LUNG CONDITION
Participant's Full Name													
Eligible Spouse's Full Name													
Dependent's Full Name													
Dependent's Full Name													
Dependent's Full Name													

Other Allergies: _____

_____

Other Health Conditions: _____

_____

I certify that the information on this form is correct, and authorize release of all information regarding my family's or my own medical and prescription drug history and treatment to the Plan Sponsor and to PharmaCare Direct.

Date: _____ Signature: _____

Mail this form with your copayment to:

PharmaCare Direct
P. O. Box 18910
Fairfield, OH 45018-9945

To enroll only, fax this form to PharmaCare Direct at: (866) 399-3654

Please note: Prescriptions faxed by patients are not valid and will not be accepted. To have your prescriptions faxed, please have your physician's office fax the enrollment form along with your prescriptions and a **cover sheet** to 800-236-9079.